



Policy Without Politics: The Limits of Social Engineering

Vicente Navarro, MD, DrPH, PhD

The extent of coverage provided by a country's health services is directly related to the level of development of that country's democratic process (and its power relations).

The United States is the only developed country whose government does not guarantee access to health care for its citizens. It is also the developed country with the least representative and most insufficient democratic institutions, owing to the constitutional framework of the political system, the privatization of the electoral process, and the enormous power of corporate interests in both the media and the political process.

As international experience shows, without a strong labor-based movement willing to be radical in its protests, a universal health care program will never be accepted by the US establishment. (*Am J Public Health*. 2003; 93:64–67)

A DETAILED ANALYSIS OF THE literature on comparative studies of health care systems shows a certain naïveté in the understanding of how a country's health care system comes about. Most authors tend to analyze and describe the differences among health care systems, trying to learn the good and not-so-good features of each system and drawing conclusions about the need to copy the positive features and reject the negative ones. Health care systems are thus conceptualized as machines and or-

ganizations consisting of different components that can be exported to other countries. In these social engineering types of studies, not much attention is paid to the political context that determines the nature of health care systems.

The historical and political roots of health care systems are rarely analyzed. And when they are, the analyses tend to assume that health care systems, at least those in democratic societies, are the outcome of people's desires. In other words, the health care systems in democratic societies are supposedly the result of what people express through their democratic institutions, such that every country has the health care system that the majority of its people chooses.

THE "DEMOCRATIC" TRADITION

The best-known historical analysis of US medicine, that is, Paul Starr's Pulitzer Prize-winning *The Social Transformation of American Medicine*, concluded with the statement that "the future of American [by which Starr means US] medicine depends on the choices that Americans [i.e., US citizens] have still to make."¹ In this reading of our democratic process, Starr makes the following assumptions: (1) popular values (and the choices they determine) generate the policies developed by the US government; (2) US political institutions

are truly representative of popular wishes; and (3) US public policies (including the funding, organization, and regulation of medical care) respond to popular mandates.

What is remarkable in this uncritical reading of the democratic process of the United States is that it is constantly reproduced by the country's dominant means of information and persuasion that define "the conventional wisdom," despite the robust empirical evidence that challenges all three of Starr's assumptions. Actually, most US citizens (whose wisdom is derived from their own experience and perceptions) would question each one of those assumptions. According to most polls that have asked people's opinions about their government, the majority of respondents believe that US political institutions are not representative of the overall population and that US public policies are a result of the influence of major economic and financial interests for whom the specific policies are being developed.

The evidence for popular distrust of US government is overwhelming. And the perception that US democracy is not working satisfactorily is widespread. Democracy is indeed limited in the United States²—and so is its welfare state. Navarro and Shi³ have shown that among developed capitalist countries, there is a clear relationship between the

degree of development of the country's democratic process (and the power relations in that country) and the expansion of its welfare state, including its health services.

THE LIMITATIONS OF US DEMOCRACY

The United States, the only developed capitalist country whose government does not guarantee access to health care as a right of citizenship, has an underdeveloped democratic process, rooted in the US Constitution. In spite of its excellent opening—"We, the people"—the Constitution establishes a political system that seriously excludes (even today) large sectors of our population. Indeed, owing to the allocation of 2 senators for each state (regardless of how populous the state), we have a situation in the US Congress in which half the US population (the half that resides in the most progressive parts of the country) is represented by just 18 senators, while the other half (primarily in the conservative states) is represented by 82 senators. This situation makes "the US Senate one of the most under-represented legislative bodies in the world," as it was recently put by Professor Robert Dahl, former president of the American Political Science Association.⁴

Moreover, the majority system of the electoral process in the United States (in which "the win-



ner takes all”—that is, gets all the seats) preempts the possibility of establishing new parties (besides disenfranchising those voters who chose the losing candidate and thus do not have any representation), as occurs in proportional systems.⁵ Further limiting the democratic potential of the country’s representative institutions, the US political process is the only one among Western democracies that is privatized—that is, the funding of political parties and candidates is primarily private, giving enormous power to those who finance the process. Most of this funding comes from major economic, financial, and professional groups, who hold a disproportionate influence in determining public policies.⁶

All these factors (the nature and funding of the US political system), plus the limited diversity of the US media (clearly tilted toward conservative biases), lead to the conclusion that US democracy is one of the most limited democracies among the developed capitalist countries. This is why the United States is the only major country without a national health program.⁷

THE INTEREST GROUP TRADITION

Because of the clear limitations of the complacent and uncritical view of US democracy that claims that the lack of a national health program is based on popular opinion and choice, another school of thought has arisen that roots the absence of a national health program in the

different levels of influence of various interest and power groups over the executive and legislative branches of the US government. These types of analyses have produced very valuable information, especially the journalistic accounts of who pays for whom in the political process (what we may call the “hanky-panky” of politics).

There are many books and articles on this “power group” type of analysis. Among the classics is that by Marmor⁸; within the radical tradition, the best known is by Ehrenreich and Ehrenreich.⁹ What these analysts miss, however, are the structural elements that configure the political context in which these various influences occur. In other words, the members of these interest groups are also members of a class, a race, and a gender that define the context in which political interactions take place. It would be wrong, for example, to try to understand the health policies of a country like South Africa during the apartheid regime—in which race was a foremost category of power—by looking only or primarily at the influence on the South African government of the pharmaceutical, insurance, hospital, and other interest groups. Obviously, these interest groups should be analyzed within a political context in which a critical group—the White race—historically wielded enormous power over another group—the Black race.

Similarly, it is limiting to study the health policies of the United States by looking primarily or exclusively at the power of interest

groups in shaping these policies. However powerful these interest groups might be, they still operate within a context in which class power, as well as race and gender power, has an even larger influence. These power relations determine the context in which interest groups interact and influence the US government.

Indeed, the limited degree of democracy in the United States and the absence of a national health program are the consequences of the enormous power of what in the United States is called the corporate class and in other countries is called the capitalist class. If we arrange countries along a spectrum, with at one pole “capitalist-friendly” countries, in which the corporate class is very strong, and at the other pole “worker-friendly” countries, in which the corporate class is weak and the working class is strong, we find that the latter countries have comprehensive, universal health care programs and the former have weak, limited health benefits coverage.¹⁰

Countries where the working class is strong (with strong unions and long periods of government by social democratic parties) and the corporate class is weak, such as the Scandinavian countries, have national health systems that tend to be run by the counties and municipalities. In these countries of social democratic tradition (Sweden, Norway, Denmark, and Finland), social democratic parties have governed for most years during the period 1946 to 1998. An average of 70% of the labor force is unionized, with

highly centralized and powerful unions negotiating collective bargaining agreements (which cover almost the entire labor force) with employers’ associations.

These worker-friendly countries are also those with large public social expenditures (31% of gross national product [GNP]) and a large percentage of public employment in the health care, education, and social service sectors (18% of the adult population work in these services). These countries have highly redistributive public policies, the smallest wage differentials and family and household income differentials, and the least poverty.

The worker-friendly countries are also the most womenfriendly. Consequent to the social democratic commitment to equality of the sexes, women are provided with family supportive services, such as child care and home care services, that enable them to combine their family and professional responsibilities. As a consequence, 70% of women are in the labor market. Moreover, there is an effort to change gender roles, such that men are educated in traditionally defined women’s roles and vice versa. For example, men spend on average 16 hours per week performing family chores, and while there are still differences (women spend on average 22 hours on family chores) that need to be corrected, the differences are minor. The worker-friendly countries are also those with greater public coverage of medical and social care, greater public employment in health care, and lower infant mortality rates.



At the other pole of the class power spectrum is the United States, the least worker-friendly and most capitalist-friendly society. In the United States, the working class is very weak and what is called the corporate class is enormously powerful. The latter class has a dominant influence in the US Congress and media (and academia). Only 14% of workers are unionized, and less than 20% of the labor force is covered by collective bargaining agreements negotiated by trade unions. Labor rights are very limited.^{11–14} Social public expenditures are low (14% of GNP), public funding of health care is low (5.1% of GNP), and public medical care coverage is also very low (48% of the total population). Wage, household, and family income differentials are very high, and poverty is also very high. The United States also has the highest infant mortality among the developed capitalist countries.

The private, employer-based type of health insurance in the United States was a result of the Taft–Hartley Act of 1947, which forced the working class and its unions to bargain with their employers for their health benefits coverage. The act forbade the US working class from acting as a class by making sympathy strikes illegal—forcing them instead to act as an aggregate of interest groups. The huge variety and irregular coverage of health benefits in the United States is rooted in the enormous power of the corporate class and the disaggregation of the working class and popular social movements. In the

absence of class mobilizations, the social movements tend to focus on age, race, and gender rather than on class, weakening their own impact. The United States, for example, has a seemingly very powerful elders' group, the American Association of Retired Persons. Yet, lacking a social democratic party and movement that could relate this elders' movement with other sectors of the working and middle classes, the elderly in the United States are less protected by health benefits than are those of other democracies—where elders may not have a special association but do have strong labor and class-oriented social democratic movements.

Similarly, the United States has a very strong feminist organization, the National Organization for Women. Yet the system of family-oriented public services is much less developed than in countries with strong labor and social democratic movements. In the United States, the disaggregation of the rebellious forces is their major weakness. This is why the United States will not have a universal health care program until a strong labor and social democratic movement develops that can push for this objective.

Occupying an intermediate place on the class-power spectrum is the Christian democratic tradition (or conservative tradition rooted in the Christian tradition). In this tradition, the welfare state, established by Bismarck, was based on an insurance system in which health benefits coverage, for example, was based on

contributions from employers and workers into social security trust funds that paid for health care. Since the health care benefits depended on the contributions of employers and workers, these countries (Germany, France, the Netherlands, Belgium, and other continental European countries) did not provide universal health benefits coverage, nor was their coverage the same for all insured people. Only the pressure of labor or social democratic parties forced a change to the comprehensive, universal coverage that now exists in these countries.

CONCLUSION

From this understanding of our realities, it appears that unless a better balance between the corporate and working classes is achieved in the United States, the country is most unlikely to adopt the principle of universal health care benefits. It is erroneous, therefore, to look at our realities from a social engineering perspective, analyzing what we can learn from specific features of other health care systems without looking at the political contexts that shaped those systems.

The maximum expression of this erroneous social engineering approach appears in Putnam's latest book, *Bowling Alone*, in which he makes the extraordinary claim that the major reforms that took place in the United States during the Progressive Era were the result of the great foresight of elites who realized the importance of what he calls "social capital" for building

up cohesive communities.¹⁵ Putnam bases social change in the existence of enlightened social engineers, completely ignoring the enormous class pressures of that time from major labor rebellions and agitation (and from women in the suffragette movement). (See reference 16 for a critique of Putnam's thesis.)

Change in the United States has taken place as a consequence of enormous struggle. Further change will occur only with large mobilizations (similar to the Civil Rights movements of the 1960s) to force change. Such change can start in one state—as it did in one Canadian province under pressure from a social democratic movement that later became a social democratic government—and then extend to other states. And in this mobilization, the labor movement will have to play a major role. I am not minimizing the important role of progressive professionals in providing valuable information and support to these movements. But the most important historical lesson is that without a strong, labor-based movement that is willing to be radical and outrageous in its protests (as in Seattle, with the antiglobalization mobilization), the principle of universal health care will never be accepted by the US establishment. ■

About the Author

The author is with the Department of Health and Public Policy, Johns Hopkins University, Baltimore, Md.

Requests for reprints should be sent to Vicente Navarro, MD, DrPH, PhD, Johns Hopkins School of Hygiene and Public Health, Hampton House, Room 448,



624 N Broadway, Baltimore, MD
21205 (e-mail: vnavarro@jhsph.edu).
This article was accepted September
10, 2002.

References

1. Starr P. *The Social Transformation of American Medicine*. New York, NY: Basic Books; 1983.
2. The US political institutions [public opinion poll]. Washington, DC: Gallup Organization; 1998–2001.
3. Navarro V, Shi L. The political context of social inequalities and health [expanded in: *Int J Health Serv*. 2001; 31:1–21]. *Soc Sci Med*. 2001;52: 481–491.
4. Dahl R. *How Democratic Is the American Constitution?* New Haven, Conn: Yale University Press; 2002.
5. Scialabba G. Democracy—proof. *American Prospect*. July 1, 2002:34–36.
6. Palast G. *The Best Democracy Money Can Buy*. London, England: Pluto Press; 2002.
7. Navarro V. Why some countries have national health insurance, others have national health services, and the US has neither [expanded in: *Int J Health Serv*. 1989;19:383–404]. *Soc Sci Med*. 1989;28:887–898.
8. Marmor T. *Political Analysis and American Medical Care*. New York, NY: Cambridge University Press; 1986.
9. Ehrenreich B, Ehrenreich J. *The American Health Empire*. New York, NY: Random House; 1971.
10. Navarro V, ed. *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life*. Amityville, NY: Baywood; 2002.
11. Human Rights Watch. Case studies of violations of workers' freedom of association: service sector workers. *Int J Health Serv*. 2001;31:793–813.
12. Human Rights Watch. Case studies of violations of workers' freedom of association: manufacturing workers. *Int J Health Serv*. 2002;32:359–378.
13. Human Rights Watch. Case studies of violations of workers' freedom of association: migrant agricultural workers. *Int J Health Serv*. 2002;32:443–465.
14. Human Rights Watch. Case studies of violations of workers' freedom of association: food processing workers and contingent workers. *Int J Health Serv*. 2002;32:755–780.
15. Putnam R. *Bowling Alone: The Collapse and Revival of American Community*. New York, NY: Simon and Schuster; 2000.
16. Navarro V. A critique of social capital. *Int J Health Serv*. 2002;32: 423–432.